VSH Futures Care Management & In Patient Work Group
June 9, 2006

Participants

Bob Pierattini, FAHC/UVM; Tom Simpatico, VSH/UVM/FAHC; Paul Landerl, HCHS; Jeff Rothenberg, CMC; Anne Donahue, Counterpoint & Legislature; Isabelle Desjardins, FAHC/UVM; Cindy Thomas, VDH; Peter Albert, Retreat Health Care; Todd Centybear, HCHS; JoEllen Swaine, VSH/VDH; Larry Thomson, VSH/VDH; Richard Lanza, LCMH; Michael Sabourin, Advocate/NKHS;; Stuart Graves, WCMHS/NKHS; Sandy Steingard, HCHS;; Patti Barlow, VDH; Paul Blake, VDH; Michael Hartman, WCMHS; Scott Thompson, Advocate/LCMH.

Staff

Beth Tanzman & Judy Rosenstreich, VDH

Agenda

Develop a recommendation about bed capacity to replace VSH.

Discussion

Beth reviewed the VSH Futures plan and the actuarial study by Milliman, Inc. Participants offered their analysis of the needs on the system based on current pressures. Summary highlights of the discussion follow.

- The relative strength of the community services infrastructure directly impacts the need for acute resources. The stronger the capabilities of the community system the less we need inpatient beds.
- Use a longer timeframe than 2016 – suggestion of 2020-2030
- We do need to resolve the question of how many inpatient beds Corrections needs
- We need a system that has enough capacity to manage dangerous situations most of the time
- It would be best to approach the question of bed capacity in a modular fashion in which resources can be expanded or contracted based on need.
- Cultural factors, such as acute admission criteria and what insurance will pay for, are more influential in determining bed utilization than are epidemiological or actuarial science.
- Any "number" we choose will be wrong. There is no single correct range. The system itself, the demands and the opportunities are too dynamic.
- There is a widely held sense that the current system (both inpatient and community) is saturated and that new capacities and more consistent funding are needed. This is especially true for case management, residential and adult outpatient services.

- From a clinical perspective, it is important to more rapidly treat people to avoid refractory illness
- Also, from a clinical perspective, voluntary engagement in services produces the best outcomes.
- We, this system, will be in serious trouble if we do not do more to sustain the current services.
- The analogy of a lake and wetlands: the lake is acute care and the wetlands the community system. Together they form an eco-system of interdependence.
- The variables impacting on needed capacity cannot be scientifically predicted. Therefore, the message to take forward is one with contingencies such as: we can shrink the number of inpatient beds if we can develop clinical systems and although we need to pick a number, it cannot be treated as static.
- How can we be fourth in the nation in per capita expenditures and be saturated? We need to make a better or different case for new community resources because a skeptical legislature may assume that the funding is already sufficient.
- Crisis bed programs report that they are under-funded. The regions that do not have crisis beds say that they could divert hospital admissions if they had such a resource.
- There is real risk in building too many inpatient beds; this will draw away resources from the community. The care management system could really deliver a lot of assistance for more appropriate utilization.
- Each point we make is about a system and not merely beds. Do we build a system that has just enough capacity or one with extra capacity?
- The state hospital bed utilization range for other states is so wide that is shows there is no correct single number.

Moving towards closure

Bob offered the following motion, seconded by Sandy:

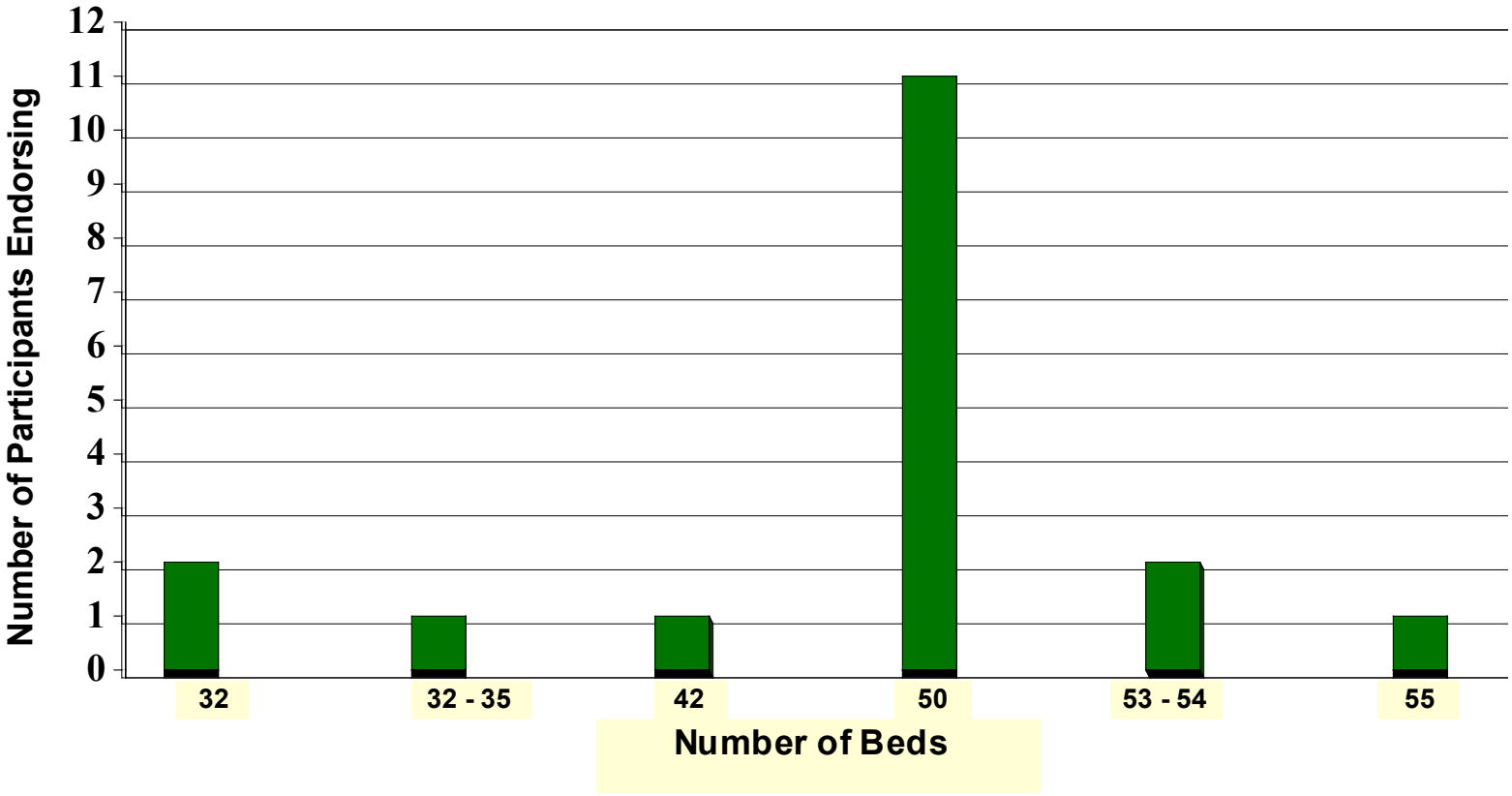
The following bed capacity recommendation is predicated on:

1. Full implementation of the Futures Plan including the as yet un-funded recommendations for MH Services in Corrections and Adult Outpatient (reference Secretary Charlie Smith's recommendations to the Legislature 2/4/05); and

2. the commitment to fully fund the community system (sustainability).

50 Beds overall; at least 32 of which are built with FAHC; 8 with RRMC and the remaining balance at the Retreat. The Retreat and RRMC beds provide the system ability to expand or contract as needed.

Each participant was asked to state their preference for bed number. The results are:


Number of Participants Endorsing
12
11
10
9
8
7
6
5
4
3
2
1
0
32
32 - 35
42
50
53 - 54
55
Number of Beds